CASE RECORD

APRIL 2012 SESSION

CERTIFICATE

This is to certify that this work titled “CASE RECORD” submitted by Dr. Swetha Raghavan as a part of fulfilment of the requirements for the Diploma in Psychological Medicine course of The Tamil Nadu Dr. M.G.R Medical University is an original and bonafide work.

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Case 1

Mr. Kalaiselvam, 34 yr male studied up to B.Sc zoology, Hindu by religion, Tamil speaking, belonging to lower socioeconomic status, unmarried, unemployed, hailing from new washermanpet, Chennai.

Informant: self, mother and brother

Information: adequate, reliable and consistent

Reasons for consultation:

- Suspiciousness for 10years
- Isrregular to job, excessive hand washing for past 7 years
- Not interacting with family members for 5 yrs
- Hearing voices for 5 years, increased for y=the past 1 1\2 months
- Suicide attempts (2) in the past one week

Onset, course and progression: insidious/ continuous/ progressive

4th admission at IMH

Precipitated and exacerbated by a stressor

HISTORY OF PRESENTING ILLNESS:

Client was apparently normal until 10yrs back, owned a petty shop, when he frequently quarrelled with his family. On enquiry he was said to have a love

affair with a girl in the neighbourhood. His parents disliked this. Meanwhile he sent a gift to the girl, for which her uncle assaulted him. Later he started expressing suspicious ideas about her uncle claiming that he had sent few men to threaten him. He also kept telling that people in the streets are talking ill of him and are plotting to kill him. He hence started taking a long route to his own shop in order to protect himself from the persecutors sent by his girl friend' s uncle. Gradually his work performance declined. He often kept his shop closed and on enquiry by parents, he would give lame excuses.

Over the next 2 yrs he was irregular to job, and began saying that he now loved another girl, a teacher. Suddenly one noon, he told his parents that his ex-girl friend's uncle had misbehaved with his new lover and that a few men tried to assault her sexually. On enquiry by his parents, all people in their locality denied about any such event. Later his business started declining further due to frequent absenteeism. Meanwhile he suddenly began washing his bike's seat every time before boarding it, claiming it was dirty. He also started sprinkling water on his shirt and hair telling that it was hot outside. At his shop also he started washing hands every time he took money from a female slum dweller. He explained that he had fear of contamination with dirt and hence his behaviour.

Gradually over the next 6 months he washed hands every time he got money from any customer. He recognised that the thoughts were his own, excessive, irrational and out of his control. If he tried to resist the thought, he would feel disgusted and would later yield to hand washing, due to this his work further declined. At home now, he started washing hands excessively after touching bathroom articles, rice sacks etc. he would water in his hands, drip it all over the floor and walk over them as the floor seemed dirty to him. Every time a visitor came home and use few articles, he would wash them and then re use. He exhibited these behaviours almost every day for the next three years.

Slowly he started keeping himself away from family members. He would not interact with them and started staying in a separate portion of their house. It was now that he started hearing voices (2-3) male and female, unknown to him, every time when he listened to the radio. He would hear these voices amidst the music and felt that the voices referred to him and discussed about him amongst themselves.

While he was alone, he began collecting pictures and articles about bombs, military tankers, and other acts of terrorism. He also started making small bombs using potassium nitrate and chemicals from match stick heads. He also made few daggers of different sizes at home. He told that he had done all this to protect himself from his ex- girl friends, uncle who was still persecuting him.

Now gradually his self care declined. He would not take bath or wash his clothes and had to be persuaded several times by his parents for the same. Later his sleep pattern changed he would keep awake until late hours listening to music. In few instances his parents had seen him, talking to himself as if answering someone. He would go to sleep by 4 am, wake up by 10 am and would hardly go for work. Until this time he said he had contact with his second girl friend over phone, after which he lost touch with her. But till this time none of his family members had seen this girl.

Apart from this he gives history of using betel nut for 10yrs and during the past five years he was abusing HANS. His parents reported violent behaviour after he began using HANS, when he was unmanageable at home, he was admitted in IMH, diagnosed as Pesudo neurotic Schizophrenia and started on C.Fluoxetine 20 mg 1-0-0, T.Risperidone 2 mg 0-0-1/2, T.Nitrazepam 5 mg 0-0-1 and was given 5 ECT's. He was discharged a week later. While on drugs, he was re admitted a week later due to poor self care and nuisance to neighbours. This time he was given T.Sodium valproate 200mg 1-1-1, T.Benzhexol 2m 1-1-0, C.Fluoxetine 20 mg 1-0-0, T.Risperidone 2 mg 1-0-2, T.Chlorpromazine 100mg 0-0-1 and 5 ECT's. He improved symptomatically and was discharged after 1 month with the same drugs. His parents also reported improvement in sleep, hand washing rituals and he was on regular treatment since then.

While on treatment he went for a job and learnt screen printing. There he was not allowed to wash hands frequently, yet he adjusted well. After 6 months, he expressed to his parents to allow him to look after their shop. Though he went to shop daily, business was dull as he continued to express suspicious ideas again about his ex-girl friend's uncle.

Until about 1 1/2 years after discharge he took drugs regularly, after which he became non compliant. Over the next few months he again started hearing voices when he listened to music on the radio. His hand washing ritual also began and his work performance began declining again.

After about 2 years of irregular treatment he began abusing HANS, and his sleep declined. He was often found walking in the terrace at mid night, peeing in to neighbours house and would sleep in the early morning hours. He again began making bombs and stayed away from family members and self care further declined. He also started becoming hostile towards his family members. Due to this his parents admitted him into a private home, where he stayed for 5 months. During his stay he was regularly given drugs and he returned home. Over the next 2 weeks he again exhibited violent behaviour and he was admitted through reception order in June 2010. He was discharged after 3 months and his inpatient stay was uneventful. After discharge his

parents admitted him into a re-habilitation centre as he began abusing tobacco.

There he was well on drugs for the next 1 month. Later he started hearing voices when he was alone. Initially it was 2-3 male and female voices, un familiar and un clear. Gradually he heard 6 voices of sexes, 3 speaking in favour of him and 3 speaking against him. They would also give running commentaries about all his actions as well as argue amongst themselves discussing about him. These voices would be heard most of the time yet he managed to sleep well at night. Initially he heard the voices from external environment and after about 2 weeks he heard a loud harsh female voice from within his heart commanding him to die by hanging himself. He tried to resist the voice, but he felt helpless and he began to feel being controlled by that voice in such a way that his hands automatically picked up a bed sheet, put it around the fan and tried to hang himself. However he was saved by other inmates. After about 2 hours of this incident, he tried to electrocute himself. This time also he said that the voice controlled all his activities and made him do so. He was thrown off by a shock, and again he was revived by other in mates and his parents were informed. His brother came next morning and took him back home.

At home that day, he complained of hearing voices and slept very little that night and feared that he would be killed. Next day he was brought and

admitted in IMH and started on T.Risperidone 2 mg 1-0-2, T.Benzhexol 2 mg 1-1-0, T.Nitrazepam 5 mg 0-0-2.

No h/o thoughts being inserted, with drawn or broad casted

No h/o low mood, guilt, hopelessness, helplessness, crying spells

No h/o elated mood, spending sprees, boastful talk

No h/o repetitive checking, counting behaviours

No h/o head injury, seizures, LOC

PAST HISTORY: nil significant

FAMILY HISTORY: First born to non consanguineous parents.

H/o mental illness in paternal uncle, who went missing 20years back.

No h/o suicides, mental retardation and substance abuse in the family.

PERSONAL HISTORY:

Ante natal, birth history: FTNVD, no birth asphyxia, normal milestones

Early childhood: no behavioural problems

Mid childhood: started schooling at 5yrs, regular to school, average scholastic performance, no sibling rivalry and no h/o truancy.

Late childhood: 10 th std: Passed with 75% marks, wanted to take computer science, but parents forced him to take biology, he passed 12 th std with 50% marks. Though he wished to join B.Sc maths, he was forced to take zoology, and has 13 arrears until now.

Adult hood: Occupational history: Was helping in fathers shop since college days. After unsuccessful college life, took up full time responsibility of their shop, saved money for him and occasionally gave for household expenses.

Marital history: unmarried

Sexual history: h\o masturbation +, no h/o sexual promiscuity

Legal history: nil

PRE MORBID PERSONALITY: Not very sociable, introvert, has very few friends.

Sensitive to criticism, nor very ambitious, not very religious and enjoy music as his pass time.

PHYSICAL EXAMINATION:

Alert, afebrile, no pallor, icterus, cyanosis, clubbing, pedal edema, generalised lymphadenopathy.

BP: 100/ 70 mmHg, PR: 76/min

SYSTEMIC EXAMINATION:

CVS: S1, S2 +, No murmur

RS: NVBS; No added sounds

CNS: NFND, Fundus: bilateral normal

ABDOMEN: soft, no organomegaly, no free fluid

MENTAL STATUS EXAMINATION: GENERAL APPEARENCE, BEHAVIOUR AND ATTITUDE: An alert, ambulant young male adequately clad in pant and shirt entered the room willingly in normal gait, cooperated for the interview, gaze contact was maintained, rapport was established, PMA was normal. No tics, mannerisms, stereotypes or abnormal involuntary movements.

Speech: Q/T/R Normal, RT: Normal, Prosody: Intact.

Sample of talk: Q1. Do you hear voices when alone?

Yes I do hear several people speaking to me, scolding me etc.

Q2. Why did you attempt suicide?

I didn't attempt, the voice instructed me, and my hands automatically picked up a cloth and put a noose around the fan and tried to hang me.

Q3. How do you feel?

I feel sad, as the voices keep disturbing me.

THOUGHT: FORM AND STREAM: Normal

CONTENT: delusion of control: He said that hands automatically picked up a bed sheet and made a noose and hung myself. It was not under my control, I felt some one made me do it.

PERCEPTION: Auditory hallucinations: II nd and IIIrd person, commanding and commenting about him.

MOOD: Sad

AFFECT: depressed, restricted in range, no lability, congruent and appropriate.

COGNITION:

Attention: arousable, Concentration: sustained

Oriented to time, place and person

Memory: Immediate, recent and remote: intact

Intelligence: average

Abstraction: Impaired for both proverbial testing and similarities and dissimilarities.

Judgement: Impaired

Insight: Absent, Grade I

INVESTIGATIONS: routine blood inv: normal

CT Brain: normal

PSYCHOLOGICAL ASSESSMENT: Psychopathological assessment brought out significant amount of positive and negative symptoms in the areas of auditory hallucinations, delusions etc. score on positive symptoms: 19, on negative symptom: 17, general psychopathology: 40. On rosarch test there was disorganisation of personality in marked in adequacy, reality touch and mentation. With these, this person has features of chronic schizophrenia with paranoid symptoms.

DIAGNOSTIC FORMULATION:

34 yr old unmarried male, studied up to B,Sc Zoology(incomplete), unemployed brought by mother and brother with c/o suspiciousness for 10 yrs, irregular to job, excessive hand washing, poor interaction with family members, hearing voices for 5yrs, 2 suicide attempts in the past 2 weeks, with significant family h/o mental illness in paternal uncle. Mental status revealed delusion of control, II and III rd person auditory hallucination, and depressed affect, with impaired abstraction, judgement and absent insight.

ICD 10 DIAGNOSIS:

F20 Schizophrenia, F 20.0 paranoid sub type.

MANAGEMENT:

He was treated with T. Risperidone 2mg 2-0-2, T. Benzhexol 2mg 1-1-0, T. Nitrazepam 5 mg 0-0-2. The need for continuous treatment, good social support and relapsing nature of the illness was explained to his relatives. They were also educated about the level of expressed emotions which would affect the recovery the patient.

CASE 2

Master. Mohammed Saif, 154yrs old boy, hailing from Chennai, discontinued schooling with 6th standard, follows Islam, is Urdu speaking and belong to lower socio economic status.

Informant (s): Parents

Information: adequate, reliable and consistent

Reasons for consultation:

Restlessness

Decreased sleep

Excessive talk, tall claims

Irritability

Assaultive behaviour

Crying spells

} for the past 3 weeks

Acute onset, episodic illness, current episode 2nd

First psychiatric consultation at IMH

No precipitating stressor

HISTORY OF PRESENTING ILLNESS:

Client was apparently normal 3 weeks back, when his parents noticed that he was very restless. He was awake all through throughout the night, wandering about the house. He stayed awake lying on his bed at times, and loitering about at other times. He never sat at one place in their house, often went out of their house. They also found him talking excessively than before and often at times his speech was irrelevant. He now started claiming that he was“ thalapathy”, no one can defeat him and he has come to this world to save the world.

He often became irritable for unprovoked reasons and assaulted his sister and mother frequently. He was also found crying occasionally for unknown reasons. When enquired about this behaviour he failed to reply and kept quiet. He also had to be reminded at times to brush, take bath, eat etc

With these complaints persisting for three weeks, he was brought to IMH for first time.

No h/o suspiciousness / hearing voices

No h/o low mood, suicidal attempts

No h/o fever/ head injury/ LOC

No h/o seizures

No h/o substance abuse

PAST HISTORY:

FIRST EPISODE: About 10 months back, he was going to school regularly, when he was suddenly found to be dull and withdrawn, not communicating well with his family members. Slowly he started saying he does not like to go to school as he has headache and remained at home. His father went to school and enquired about any problem, but his teachers denied any such event. Subsequently his sleep declined, he would either watch TV all through the night or would keep awake lying in the bed. Slowly his parents noticed that he was talking to himself as is answering someone, at times he would also laugh to himself. On enquiry, he revealed that he could hear voices of unknown people, both male and female, who told him to eat, go to school play etc. Gradually he became irritable for trivial reasons and needed to be persuaded to take bath. These symptoms persisted over the next 15 days and they took him to a private psychiatrist. He was later investigated with CT Brain and EEG which were normal and he was started on T>Haloperidol 1.5 mg 1/4-1/4-0, T.Benzhexol 2 mg 1/2-1/2-0. On taking these drugs, his sleep improved so did his interaction with family members over a period of 3-4 months.

He then started going to school on and off as he remained drowsy most of the time on drugs. He took medications regularly for the next 7 months, but discontinued the same for past 3 months, when the current episode began about three weeks back.

PAST MEDICAL HISTORY: NIL

PAST SURGICAL HISTORY: NIL

FAMILY HISTORY: First born to non consanguineous parents.

H/o frequent quarrels between parents and h/o substance abuse in father (alcohol)

No h/o psychiatric illness, mental retardation, seizure disorder and missing persons in the family

PERSONAL HISTORY:

ANTENATAL AND POST PARTUM PERIOD: No antenatal problems in the mother, FTNVD, hospital delivery, normal birth weight, no birth asphyxia, immunised adequately for age.

NEONATAL PERIOD: Uneventful

INFANCY: Exclusive breast feeding until 4 months and weaning thereafter

All milestones developed at appropriate time except for speech,. He spoke mono syllable at 3yrs, phrases at 4 years and in sentences at 5 yrs of age

EARLY CHILDHOOD: No behavioural disturbances like temper tantrums or finger sucking.

MIDDLE CHILDHOOD: Started schooling at 5 yrs of age, was regular to school, average academic performance. Failed in 3^{rd}, 4^{th} and 5^{th} standard in mathematics. Peer relations were average. No h/o conduct disturbances.

LATE CHILDHOOD: Studied up to 5^{th} standard, then attended 6^{th} standard irregularly and discontinued completely towards half yearly exams.

TEMPERAMENTAL OR PERSONALITY ATTRIBUTES

- Easy child
- Adjustable
- Inter personal relationship with parents, siblings and friends - good
- On meeting new people: Greets them and behaves appropriately
- On going to new places: Remained with parents and mingled slowly
- Used to discuss about problems, remained with parents and mingles slowly
- Aspires to become a doctor
- Religious: goes to mosque every Friday

PHYSICAL EXAMINATION:

Alert, afebrile, no pallor, icterus, cyanosis, clubbing, pedal edema, generalised lymphadenopathy.

BP: 100/80 mmHg, PR: 88/ min regular

CVS: S1, S2 +, No murmur

RS: NVBS; No added sounds

CNS: NFND, Fundus: bilateral normal

ABDOMEN: soft, no organomegaly, no free fluid

MENTAL STATUS EXAMINATION:

GENERAL APPEARANCE, BEHAVIOUR AND ATTITUDE:

Young boy, adequately dressed, well kempt, had to be forced to sit as he often tried to walk out of the room and sat with an authoritative attitude. He was fidgety, gaze contact- ill sustained, rapport-was established with difficulty motor activity-was increased, he picked up thing from the table, was easily distracted and did not cooperate much for the interview. There were no tics, mannerisms, stereotypes or abnormal involuntary movements.

Speech- spontaneous excessive speech +, relevant initially drifts to irrelevancy, pressure of speech +, Q/T/R: increased, RT: decreased

Sample of speech:

Q1. What is your name?

Saif, saifullah, nauju, nauju is my enemy, I will kill him. Am “thalapathy”, have to save people. People are important. Even if 100 people come I will fight them, I am not afraid

Q2. How are you?

Fine, happy, I can fly in the air, I have the power of electricity in my hand.

MOOD: SUBJECTIVELY: Happy, OBJECTIVELY: Elated

AFFECT: Cheerful, but irritable at times, appropriate, broad range, lability +

THOUGHT: FORM: Flight of Ideas +

STREAM: Increased

CONTENT: Inflated self esteem +

He says he is “thalapthy” and that he has come to save the people

PERCEPTION: No perceptual disturbances in any modality

PRIMARY MENTAL FUNTIONS:

ATTENTION: Arousable

CONCENTRATION: Ill sustained, hence further assessment of mental functions could not be performed in detail as he was very distractible.

INSIGHT: Absent, Grade I

INVESTIGATIONS: routine blood inv: normal

CT Brain: normal, EEG: Normal

DIAGNOSTIC FORMULATION:

14 year old boy brought by parents with c/o decreased sleep, restlessness, excessive irrelevant talk, tall claims, irritability, assaultive behaviour for 3 weeks, with past h/o antipsychotic treatment for c/o being dull and withdrawn, talking to self and hearing voices 10 months back lasting for 7 months, not on treatment for the past 3 months, with h/o poor speech development and poor scholastic performance. Mental status examination revealed a fidgety young boy, with increased motor activity, spontaneous excessive speech, distractibility, increased Q/T/R of speech, decreased reaction time, pressure of speech, cheerful mood, irritable affect and lability; Thought

form revealed flight of ideas, increased stream, inflated self esteem. Attention was arousable, concentration ill sustained and insight was absent.

ICD 10 DIAGNOSIS:

F 31.1 BIPOLAR AFFECTIVE DISORDER, CURRENT EPISODE MANIC WITHOUT PSYCHOTIC FEATURES.(Adolescent onset)

MANAGEMENT:

He was treated with mood stabilizer i.e. lithium and sodium valproate, along with benzodiazepines. He was also put on parenteral benzodiazepines on an as and when required basis. He was discharged about a month later, when his over activity and inflated self esteem had significantly declined.

CASE 3

Mrs. Jeyamani 60yr, widow, studied up to 2nd standard, converted Christian, Tamil speaking, hailing from Manaliputhur, Chennai; house wife by occupation.

Informant (s): son, daughter

Information: adequate, reliable and consistent

Reasons for consultation:

Hearing voices, talking to self, sleep disturbances, suspiciousness for 2 years

Abusive, assaultive behaviour, appetite disturbances for 4 months

Insidious onset, continuous illness, progressive course

II nd psychiatric consultation at IMH

No precipitating stressor

HISTORY OF PRESENTING ILLNESS:

Client was apparently normal 2 yrs back, when she initially began saying that she could hear Jesus speaking to her through the walls of their house. She was often seen by her son, facing the walls and muttering as if answering someone. Gradually her visits to the church increased in frequency and even at home she was seen spending time reading bible excessively than before. Even at night

during sleep, she would often get up and suddenly start doing prayer. She would continue praying until late sun rise, then sleep for a couple of hours and start her household chores. Such behaviour continued for the next couple of months.

Suddenly, one day she told her son, that here after she would not go to church or pray at home. On enquiry, she said few people in the church were threatening to kill her. He also started saying that 2 people a man and woman (named Senthuram and Poongothai) took blood from her brain. She would say that the couple had a sieve plate embedded with blades which they kept on her head, pressed it hard in order to pierce the skull and late drew blood. She also said that this couple had appointed around 150 men, to do this job and that those men had been drawing blood from her brain over the past 15 yrs. She stated that she could feel the pain of the blades piercing her skull, but she was helpless as the 150 men threatened to kill her if she resisted them and interrupted them. She continued to complain about such incidents happening to her almost daily over the next 6 months. In spite of these complaints she continued to her daily chores.

Gradually she started expressing suspiciousness towards her daughter who visited her frequently to have illicit relations with few males in their surroundings. She also frequently abused her with filthy words and prevented

her grandchildren from entering her house, stating that they too were involved in the plot of drawing blood from her brain. Later she also started suspecting her son to have illicit relations.

Suddenly one day her son saw that she had cooked large amounts of food and served it in 5 plates. She told that gods had informed her that they would visit her house and eat food there. She did not allow anyone to eat that food and later that night she discarded the food into a large vessel in their backyard. Next morning, when her saw in the backyard, he found large amounts of stale food, accumulated of the past few days. Later she disclosed that off late, gods had been visiting her frequently and that she had been serving them food all along. Now she also revealed that Lord Ayyappa was her father and Goddess Bathirakali her mother. It was through their blessing that she had been surviving all these years even though more than 15,000 thousand packets of blood had been drawn from her brain.

She also started claiming that her husband, who had died 38yrs ago, was alive and was living with them. She was often found talking to self as if answering her husband, and would tell her son to talk to him and take good care of him. All through this time she continued to say that people were drawing blood from her brain. Once she also went and complained to the police station about

this, but she was reassured and sent back home. She was also seen waving a stick around her head, trying to wade off people around her.

Gradually her sleep pattern worsened. She would wake up late into the night, keep talking to self, laugh and cry at times, then sleep for a couple of hours in the morning. With all these complains persisting over the next 8 months she was brought to IMH for the first time and started on T.Risperidone 2 mg 0-0-1/2. As she refused to take drugs at home, her son would mix it in food and give. She took drugs for next 3 days, after which she refused as she had seen her son mixing the drug in her food. Later she started eating food only from her son's plate due to suspicion.

Now for the past 4 months her sleep has further declined and eating habit has changed. Thought she cooks food, she eats only if she desires and she cannot be force to eat. She also began picking up quarrels with neighbours. She frequently went to a newly built house in their locality and fight with their owners that the plot belongs to their fore fathers and that the house has been built by her father Lord Ayyappan for her to stay. She also started abusing her family members and assaulting them for unprovoked reasons. She also kept saying that she owns lot of property given by the gods and that people are trying to steal the same. With all these complaints she is now brought for consultation at IMH.

No h/o thought insertion, withdrawal, broad cast, or audible thoughts

No h/o low mood, guilt, hopelessness, helplessness, crying spells

No h/o elated mood, spending sprees, boastful talk

No h/o repetitive checking, counting behaviours

No h/o way finding difficulty, difficulty in recognising familiar faces, forgetfulness or childish behaviour.

No h/o substance abuse.

PAST HISTORY:

H/o head injury 3 yrs back, was hit by a two wheeler. She suffered a laceration, which was sutured and investigated for the same and relatives were informed that all was fine. There was no h/o seizure/ LOC / ent bleed.

No other relevant past psychiatric history

FAMILY HISTORY:

3 rd born to third degree consanguineous parents.

H/o mental illness in the grand mother

H/o mental retardation present in her elder sister, who went missing many years back and his where about are still not known

No h/o suicides in the family

PERSONAL HISTORY:

ANTE NATAL/ BIRTH/ EARLY CHILD HOOD HISTORY: Details not available

MID CHILDHOOD: Joined school at 5yrs, studied up to 2nd std, later discontinued due to loss of interest.

Since then she engaged in household activities.

LATE CHILDHOOD AND ADOLESCENCE: Continued to work in her house

Attained menarche at 17yrs, normal cycles, regular

Married t 20 yrs, arranged marriage. No significant marital discords.

She gave birth to 2 children who are healthy. She is now being cared by her son, who is separated from his wife for the past 8 yrs.

OOCUPATIONAL HISTORY: Her husband dies when her elder son was 4 yrs old. Since then she engaged in daily wages work and worked to bring up her children. She has been very responsible and takes good care of her children.

LEGAL HISTORY: Nil

PRE MORBID PERSONALITY:

Religious, responsible, ambivert with average interpersonal relationship and no deviant personality traits

PHYSICAL EXAMINATION:

Alert, afebrile, no pallor, icterus, cyanosis, clubbing, pedal edema, generalised lymphadenopathy.

BP: 100/80 mmHg, PR: 70/ min regular

CVS: S1, S2 +, No murmur

RS: NVBS; No added sounds

CNS: NFND, Fundus: bilateral normal

ABDOMEN: soft, no organomegaly, no free fluid

LOBAR FUNCTION TESTS:

FRONTAL, PARIETAL, TEMPORAL, OCCIPITAL: No deficits.

MMSE: 26/30

MENTAL STATUS EXAMINATION:

GENERAL APPEARENCE, BEHAVIOUR AND ATTITUDE:

An alert, ambulant, thin built middle aged woman adequately clad in sari and blouse, well kempt, entered the room in normal gait, was interested and

cooperated for the interview. Gaze contact was made and maintained and rapport was established. Psychomotor activity was normal, no tics, mannerisms, stereotypes or abnormal involuntary movements.

SPEECH: Q/T/R: Normal, RT: Normal

Prosody: intact, relevant and coherent speech

SAMPLE OF TALK:

Q1. Why did they bring you here madam?

They claim I am mentally ill and hence they got me here.

Q2. Why do they say so?

I told that people are sucking blood from my brain, but they don't believe me and tell me that am mad.

Q3. Do you hear voices, even when no one speaks?

Yes I do, about 150 men keep making noises around me. Lord Ayyappan also speaks to me.

THOUGHT: FORM: Normal, STREAM: Increased

CONTENT: BIZZARE DELUSION: Blood is drawn from her brain using a sieve plate placed on her skull. About 15,000 packets of blood has been drawn over the past 15 years

DELUSION OF PERSECUTION: she says those two people in the church are plotting against her and will kill her

DELUSION OF GRANDIOSITY: Lord Ayyappan is my father and Goddess Bathirakali is my mother. I own lots of property amounting to several crore, which people are trying to steal from me.

PERCEPTION:

II AND III rd person auditory hallucinations are present. She says she hears several voices talking about her and commenting about her.

MOD: SUBJECTIVELY: am fine

OBJECTIVELY: Sad

AFFECT: Restricted, no labilty, congruent and appropriate

COGNITION:

Attention: arousable, Concentration: sustained

Oriented to time, place and person

Memory: Immediate, recent and remote: intact

Intelligence: average

Abstraction: Impaired for both proverbial testing and similarities and dissimilarities.

Judgement: Intact

Insight: Absent, Grade I

INVESTIGATIONS: routine blood inv: normal

CT Brain: normal

NEUROLOGIST OPINION: Nil contributory

PSYCHOLOGICAL ASSESSMENT:

Psychopathological assessment brought out significant amount of positive and negative symptoms in the areas of auditory hallucinations, delusions etc. score on positive symptoms: 34, on negative symptom: 15, general psychopathology: 40. On Rosarch test there was disorganisation of personality in marked in adequacy, reality touch and mentation. With these, this person has features of schizophrenia with paranoid symptoms.

DIAGNOSTIC FORMULATION:

60yr old widow, brought by children with c/o hearing voices, talking to self, sleep disturbances, suspiciousness, for 2 yrs; poor appetite, abusive and assaultive behaviour for 4 months, insidious onset, progressive course with family h/o mental illness in grandmother, mental retardation in elder sister, with normal lobar function tests and MMSE score of 26/30.

MSE revealed bizarre delusions, delusion of persecution, delusion of grandiosity, auditory hallucinations (II & III rd person), and restricted affect, with impaired abstraction and absent insight.

ICD 10 DIAGNOSIS:

F20 Schizophrenia, F 20.0 paranoid sub type. (Late onset)

MANAGEMENT:

She was started on low dose antipsychotics T. Risperidone 2mg 0-0-1/2, T. Benzhexol 2 mg 0-0-1, T. Lorazepam 2 mg 0-0-1. After about 3 days dose was increased to 2mg of risperidone at night, to which patient responded well and she was discharged 2 weeks later. Her children were educated about the need for continuous treatment and the relapsing nature of the illness and the need for good social support which will help her improve her faster and maintain remission.

CASE 4

Mr. Kalaivanan, 27 yr, male, salesman by occupation, studied up to 8th standard, Hindu, Tamil speaking, unmarried, belongs to lower socio economic status.

Informant(s): self and mother

Information: adequate, reliable and consistent

Reasons for consultation:

Alcohol consumption for 7 years

Daily drinking and early morning drinking for 3 years

Sleep disturbances
Appetite disturbances
Anger outbursts
Irregular to job
} for 1 year

Insidious onset, continuous illness, progressive course.

First psychiatric consultation.

No precipitating stressor.

HISTORY OF PRESENTING ILLNESS:

Client was apparently working as a salesman in a plastic company, was regular to job, when he was introduced to alcohol by his colleagues on a festive occasion. He initially drank a large glass of beer, experienced high, nausea, vomiting and there after stopped drinking for next 1 month. Then he drank beer again, but did not experience any side effects and thereafter began drinking over the weekends. Over the next 6 months he drank beer. For trial he drank brandy once and experienced much more high than beer. Since this alternative was cheaper and gave more high, he thereafter continued brandy one quarter i.e. 180ml over weekends for the next 1 year. Gradually he increased the quantity to 360ml as he did not experience high with 180ml. now he began drinking 3 days a week, as he got tremors when he did not drink. Over the next 6 months both the quantity and frequency of drinking increased.

Now for the past 3 years he drinks daily about 360-540 ml. He begins drinking early in the morning as he develops tremors if he does not drink. After the first drink of about 90 ml he goes to job. Then around 12pm he again consumes around 90ml of brandy and continues to work, though he gets in to unnecessary quarrels with his employers due to the same. Later towards the evening he again consumes 180ml of alcohol in an intoxicated state.

For the past 1 year he has developed sleep disturbances. He finds it difficult to fall asleep and also gets frequently awakened during the sleep. When he gets awakened in sleep he consumes around 60-90 ml of left over brandy and tries to resume back to sleep. Morning while getting up itself the first he does is to search for left over brandy or searches for money to buy, or for articles to be mortgaged for the same he has incurred lot of debts due to his behaviour of daily uncontrollable drinking. His prime interest for the past 1 year is in procuring alcohol and he ignores all his alternative sources of pleasure. Apart from these he also has poor appetite and eats very inadequately. At home when he returns in an intoxicated state he gets in to quarrels with his parents for trivial reasons. When questioned about his behaviour the previous night, on few occasions he failed to recall what had happened the previous night.

No h/o hematemesis, malena, jaundice

No h/o head injury, seizures, LOC

No h/o hearing voices, talking or laughing to self

No h/o elated mood, spending sprees or boastful talk

No h/o crying spells, suicidal attempts

No h/o recurrent intrusive thoughts/ images

No h/o repetitive acts

No h/o using tobacco or other substances

Last drink of alcohol: yesterday night 180ml

PAST HISTORY: Nil

FAMILY HISTORY: Born as first child to non consanguineous parents with h/o alcohol dependence in paternal uncle and father who are not on treatment. No h/o psychiatric illness, mental retardation, suicides, seizure disorder and missing persons in the family.

PERSONAL HISTORY:

EARLY CHILDHOOD: FTNVD, No birth asphyxia, no post partum complications. All milestones were normal.

MIDDLE CHILDHOOD: Joined school at 5 years of age, was regular to school, no h/o truancy, was average in scholastics.

LATE CHILDHOOD: Continued schooling until 8^{th} standard, later discontinued schooling due to financial constraints as father had stopped working and he began working in a mechanic shop as an assistant.

ADOLESCENCE AND ADULTHOOD: He worked in the same shop until 20years of age and then with the help of his friends got the job of a salesman in a plastic

company. He goes to that job for the past 7 years but now for the past 6 months he is irregular to the job due to his drinking habits.

MARITAL HISTORY: Unmarried

SEXUAL HISTORY: No h/o sexual exposure

HABIT HISTORY: As detailed above

LEGAL HISTORY: Nil

PHYSICAL EXAMINATION:

Alert, afebrile, no pallor, icterus, cyanosis, clubbing, pedal edema, generalised lymphadenopathy.

Bilateral tremors of hands +

BP: 110/70 mmHg, PR: 80/ min regular

CVS: S1, S2 +, No murmur

RS: NVBS; No added sounds

CNS: NFND, Fundus: bilateral normal

ABDOMEN: soft, no organomegaly, no free fluid

MENTAL STATUS EXAMINATION:

GENERAL APPEARANCE, BEHAVIOUR AND ATTITUDE:

Alert, young male, adequately clad, well kempt, entered the room in normal gait, was accompanied by his mother. He was interested in the interview, gaze contact was maintained, rapport was established, motor activity was normal, no tics/mannerisms/stereotypes/abnormal involuntary movements were noticed.

Speech: Q/T/R Normal, RT Normal, prosody intact.

SAMPLE OF SPEECH:

Q1. Why do you want to quit alcohol?

I want to quit it as it has caused sleeplessness, tremors and I have lot of debts to repay.

Q2. Why are you irregular to job?

When I drink at work place I get into fights with my employer, hence I avoid going to job mostly, due to which I have lost my livelihood.

Q3. Are you motivated to quit?

Yes I am, so that I can regain all the lost things in my life.

THOUGHT: FORM AND STREAM: Normal

CONTENT: No abnormal content

PERCEPTION: No perceptual disturbances in any modality

MOOD: SUJECTIVELY: Normal

OBJECTIVELY: Euthymic, reactive, congruent, appropriate, no lability

COGNITION:

Attention: arousable, Concentration: sustained

Oriented to time, place and person

Memory: Immediate, recent and remote: intact

Intelligence: average

Abstraction: Intact

Judgement: Intact

Insight: Grade 4

Motivation: stage 3

INVESTIGATIONS: routine blood inv: normal

USG ABDOMEN: Fatty liver

PSYCHOLOGICAL ASSESSMENT:

This person was assessed with CAGE and AUDIT questionnaires. He showed high levels of dependence on both the questionnaires. His motivation was assessed using readiness to change (RTC) questionnaire, which showed moderate level of motivation. There was no other psychopathology noted.

DIAGNOSTIC FORMULATION:

27year old unmarried male, brought by mother with c/o alcohol consumption for the past 7 years, daily drinking, early morning drinking for 3 years, poor sleep and appetite, anger outbursts, irregularity to job for past 1 year with positive family history of alcohol dependence in father and paternal uncle. Physical examination revealed tremors of both hands, MSE revealed no significant abnormality in thought, perception with intact cognitive functions, insight grade 4, and motivation stage 3.

ICD 10 DIAGNOSIS:

F 10.20 Mental and behavioural disturbances due to the use of alcohol, dependence syndrome, currently abstinent.

MANAGEMENT:

He was admitted as inpatient and started on detoxification regimen with benzodiazepines, vitamin supplements along with parenteral thiamine. During the inpatient stay, he attended group sessions on benefits of quitting alcohol and also counselling sessions on how to identify and avoid high risk situations and how to be affirmative with those people who tend to remind him of alcohol consumption. Family counselling was also done.

CASE 5

Mr. Kamal Raj, 25yr male, unmarried, studied up to 8th standard, salesman by occupation, follows Christianity, Tamil speaking, hails from Chennai and belongs to lower socio economic status.

Informant (s): Mother

Information: adequate, reliable and consistent

Reasons for consultation:

Reduced sleep

Irritability

Abusive and assaultive behaviour

Reduced food intake — 5 years

Self injurious behaviour

Claiming himself as Lord Jesus

Claiming that his sister in law and other women are trying to provoke sexual thoughts in him

Insidious onset, continuous illness, waxing and waning course

Ist psychiatric consultation at IMH, No precipitating stressor

HISTORY OF PRESENTING ILLNESS:

Client was apparently normal 5 years back, going to work regularly as an electrician. One evening he began laughing to himself and on enquiry by his parents he failed to reply. He did not sleep the whole night. The following day he was taken to church, where he remained quiet, but after returning home he became abusive and assaultive, and started shouting at his family members. He was later forcibly locked in a room and he remained sleepless the whole night. Consequently he was taken to a physician next day, who referred him to a psychiatrist. On consulting the psychiatrist he was admitted and treated with parenteral injections and discharged after 10 days.

Later he took drugs regularly, his sleep improved, but he stayed at home not going for work over the next one year giving lame excuses. He also became irritable at times for unprovoked reasons. A year later he again began working in a moulding factory and took drugs regularly. About 2 years after the first episode he again became sleepless, developed anger outbursts and assaultive behaviour. He also displayed self injurious behaviour by cutting his hand. When prevented by parents from doing so and on being enquired about his behaviour, he said he didn't know why he cut he hands. He was again taken to the same psychiatrist and treated over the next 3 months (details of treatment

and follow up are not available). Over the next 6 months his symptoms worsened gradually and he was treated with ECT. He was well over the next 4 months, when his brother got married. Later his work performance declined and he frequently absented himself from his work place. He explained to his mother that began seeing women naked even when they were dressed and hence he stopped going for work.

He told his mother to arrange for his wedding with a girl named 'viji' whose existence is still a doubt among their family members. He slowly developed sleep disturbances, was assaultive towards his brother claiming that he was doing harm. He also claimed that his sister-in-law was trying to misbehave with him sexually and also claimed that few other women in there are also behaved the same way, which he disliked. His mother hence started to take him for prayer meetings. During the prayer time one day, he began claiming that he is Lord Jesus and asked his mother to worship him. He said he was bestowed with divine powers and had to protect this world from evil spirits. Along with this behaviour he also displayed reduced appetite, self injurious behaviour by trying to cut his hand and also attempted to jump from a well near his house.

He was then treated by a psychiatrist with T. Olanzapine 5mg 0-0-1, T.Dicorate ER 500mg 0-0-1, T.Trinicalm forte 0-0-1, T.Haloperidol 5mg 0-0-1. While on drugs for 1 week, he became assaultive, and tried to assault his pregnant

sister-in-law. Later that evening he tried to hang himself and next morning he was taken to government (KMC) hospital and was diagnosed to suffer from Schizophrenia on irregular treatment. A CT Brain was taken and it showed Calcification Right High frontal region and neurologist opined, nil neurological intervention for the same. He was started on T.Risperidone 2mg 1-0-1, T.Benzhexol 2mg 1-0-0, T.Diazepam 5 mg 0-0-1, T.SVP 200mg 1-0-1. With no significant improvement he was readmitted in KMC and risperidone was stopped and he was started on haloperidol along with other previous medications. He was discharged after one week with Inj. Fluphenazine im once in 2 weeks for the next 2 months. He showed no improvement and was very aggressive, trying to cut his neck and strangulate himself. With these complaints he was referred t IMH from KMC, for institutional care.

He was admitted for a period of 45 days and his drug prescriptions were changed from time to time depending on his improvement. On discharge he was prescribed T.Lithium 300mg 1-1-2, T.Risperidone 2mg 2-0-2, T.Benzhexol 2mg 1-0-1, and T.Diazepam 5 mg 0-0-3. About a week after discharge he was again brought back by his family stating that his symptoms had worsened. He was admitted and started on his last prescription. As his symptoms did not improve over the next 4 days, all drugs were tapered and stopped in the subsequent 4 days. He displayed irrelevant talk, claimed that his thoughts were

known to others, few other inmate of his ward were taking away his powers by touching him etc. He was started on T.Trifluoperazine 5mg 1-1-1, T.Benzhexol 2mg 1-1-1. T. CPZ 100mg 0-0-2.

No h/o low mood, crying spells

No h/o fever/ head injury/ LOC

No h/o seizures

No h/o substance abuse

PAST HISTORY: PSYCHIATRIC: Nil

MEDICAL: H/O seizures once at 10years of age, treated in ESI, as ?SOL . he was treated with parenteral and oral drugs for 3 months after which CT Brain was taken and he was informed to be cured and advice to stop drugs.

FAMILY HISTORY:

Last born to a non consanguineous couple and has 3 elder siblings

H/o alcohol abuse in father, who is now abstinent for 15years

No h/o psychiatric illness, mental retardation, seizure disorder and missing persons in the family.

PERSONAL HISTORY:

EARLY CHILDHOOD: FTNVD, no birth asphyxia, milestones were appropriate for age

MIDDLE CHILDHOOD: Started schooling at 3 years of age. Studied up to 5th standard in private school, then he continued in government school. Average scholastic performance. No h/o conduct disturbance

LATE CHILDHOOD: Did not study beyond 8th standard due to loss of interest and he completed 8th standard only by the age of 17years. Later he learnt electrical work and started his career as electrician

ADULTHOOD:

OCCUPATIONAL HISTORY: Continued to work as electrician until then illness began about 5 years back

MARITAL HISTORY: Unmarried

SEXUAL HISTORY: No h/o any sexual contacts

LEGAL HISTORY: Nil

PREMORBID PERSONALITY: Sociable, cheerful, adamant, affectionate, had many friends, good interpersonal relations with the family members.

PHYSICAL EXAMINATION:

Alert, afebrile, no pallor, icterus, cyanosis, clubbing, pedal edema, generalised lymphadenopathy.

BP: 110/70 mmHg, PR: 80/ min regular

CVS: S1, S2 +, No murmur

RS: NVBS; No added sounds

CNS: NFND, Fundus: bilateral normal

ABDOMEN: soft, no organomegaly, no free fluid

MENTAL STATUS EXAMINATION:

GENERAL APPEARANCE, BEHAVIOUR AND ATTITUDE:

Alert, young male, adequately clad, well kempt, entered the room in normal gait, was apprehensive at times when someone crossed him and started talking only after he checked that the passerby had left the interview room. Gaze contact was maintained, rapport was established, motor activity was

increased, and no tics/mannerisms/stereotypes/abnormal involuntary movements were noticed.

Speech: Q/T/R Normal, RT Normal

SAMPLE OF SPEECH:

Q1. How do you feel?

Am happy, am lord Jesus, I don't have worries, I am here to save the people and free them from all sorrows

Q2. Do you hear voices when no one speaks to you?

No I don't.

Q3. Do you feel that peoples face changes when you look at them?

Yes, my mother's face and mine too changes for some time, gets replaced by a new face but later returns to the original one. I don't how this happens.

THOUGHT: FORM: Tangentiality

STREAM: Thought block +, he stops conversing in between and after a while says he forgot what he was talking about and begins the topic only if he is given clues.

CONTENT: Delusion of Grandiosity

He says he is “DEVAN”, he has all the powers to do anything, he can heal all people’s pain and protect everyone from evil spirits.

Delusion of Metamorphosis

He says that his face has changed to some other man’s face. He also says that in a similar way his mother’s face also changes to other women’s faces and it later returns to her original face.

PERCEPTION: No perceptual abnormality

MOOD: Normal

AFFECT: Anxious at time, otherwise euthymic, restricted, appropriate, no lability.

COGNITION:

Attention: arousable, Concentration: sustained

Oriented to time, place and person

Memory: Immediate, recent and remote: intact

Intelligence: average

Abstraction: Impaired for both proverbial testing and similarities and dissimilarities.

Judgement: Intact

Insight: Grade 4

INVESTIGATIONS: routine blood inv: normal

CT Brain: normal

PSYCHOLOGICAL ASSESSMENT:

Tests given to this patient were SSI, MPQ, PANSS, SAPS, BPRS, YMRS, Rosarch Ink Blot test. On MPQ & SSI he got significant scores on paranoid and schizophrenia. On PANSS & BPRS he gets elevated scores on areas of delusions, grandiosity, persecution, conceptual disorganisation etc. On rosarch he has below average productivity, poor form level, blocking and few popular responses. From the history and psychometric assessment, he gets significant scores on paranoid & schizophrenia with predominant delusions.

DIAGNOSTIC FORMULATION:

25yr old male with c/o reduced sleep, irritability, abusive and assaultive behaviour, reduced food intake, self injurious behaviour, claims of being provoked by women in a sexual manner, and claiming himself as Lord Jesus for

5 yrs, insidious onset, continuous illness, waxing and waning course, with h/o irregular medications in the past and h/o seizure and ? SOL treated at 10 yrs of age and family h/o alcohol abuse in the father. MSE revealed increased motor activity, tangentiality, thought block, delusion of grandiosity, delusion of metamorphosis, anxious affect, restricted in range, impaired abstraction and partial insight.

ICD 10 DIAGNOSIS:

F 20.3 SCHIZOPHRENIA, UNDIFFERENTIATED SUBTYPE.

MANAGEMENT:

He was treated with antipsychotics as follows T.Trifluoperazine 5mg 1-1-1, T.Benzhexol 2mg 1-1-1. T. CPZ 100mg 0-0-2 and discharged a month later. Family oriented psycho therapy, psycho education etc. was given to his family and the need for strict compliance was emphasized. Social skills training was also imparted to the patient during his follow up sessions.